



Contact Summary Report for Perinatal Hepatitis B

Infectious Disease Intervention and Control Branch
 Texas Department of State Health Services
 1100 West 49th Street/ Mail code 1939
 Austin, Texas 78756
 FAX: (512) 458-7787 PHONE: (512) 458-7447

Contact's Information:

Enrollment Date: ____/____/____
 mm dd yyyy

ID#: ____/____/____/____
 yr / county/mother/hh#

Last Name: _____ First Name: _____ DOB: _____
 First Name of Index Case: _____ Last Name of Index Case: _____
 Relationship of Index Case: _____
 Address: _____ City: _____ Zip: _____ County: _____
 Home Phone: _____ Work Phone: _____ Medicaid #: _____ SS#: _____
 Race/Ethnicity: _____ Country of Birth: _____
 Language Spoken: _____ Language Written: _____
 Alternate Contact Information: _____

Contact's Provider Information:

Doctor's Name: _____ Phone: _____ Fax: _____
 Address: _____ City: _____ Zip: _____

Contact's Hepatitis B Serology and Vaccine History:

Prior hepatitis B serology test? Yes ☐ No ☐
 Prior report HBsAg: Pos ☐ Neg ☐ Date: _____
 Prior report anti-HBs: Pos ☐ Neg ☐ Date: _____
 Prior report anti-HBc: Pos ☐ Neg ☐ Date: _____
 Prior Hepatitis B vaccine? Yes ☐ No ☐ Dates: _____, _____, _____

Results of Serology Tests for the Contact Performed After Enrollment Date:

Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor /Clinic)
HBsAg				
Anti-HBs				
Anti-HBc				

Hepatitis B Vaccine Record for the Contact – Series 1 Given After Enrollment Date:

Biological	Date	Dose	Formulation	Manufacturer	Lot Number	Provider (Doctor/Clinic)
1 st Hep B dose						
2 nd Hep B dose						
3 rd Hep B dose						

Results of Post Vaccine Serology for the Contact:

Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor/Clinic)
HBsAg				
Anti-HBs				
Anti-HBc				

Hepatitis B Vaccine Record for the Contact – Series 2:

Biological	Date	Dose	Formulation	Manufacturer	Lot Number	Provider (Doctor/Clinic)
4 th Hep B dose						
5 th Hep B dose						
6 th Hep B dose						

Results of Post Vaccine Serology for the Contact – Series 2:

Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor/Clinic)
HBsAg				
Anti-HBs				
Anti-HBc				

Date Case Closed: _____ Reason Closed: _____ Status: _____